

107TH CONGRESS
1ST SESSION

S. 452

To amend title XVIII of the Social Security Act to ensure that the Secretary of Health and Human Services provides appropriate guidance to physicians, providers of services, and ambulance providers that are attempting to properly submit claims under the medicare program and to ensure that the Secretary does not target inadvertent billing errors.

IN THE SENATE OF THE UNITED STATES

MARCH 5, 2001

Mr. MURKOWSKI (for himself, Mr. KERRY, Mr. KYL, Mr. SMITH of New Hampshire, Mr. HELMS, Mr. REID, Mrs. LINCOLN, and Mr. HAGEL) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to ensure that the Secretary of Health and Human Services provides appropriate guidance to physicians, providers of services, and ambulance providers that are attempting to properly submit claims under the medicare program and to ensure that the Secretary does not target inadvertent billing errors.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
 3 “Medicare Education and Regulatory Fairness Act of
 4 2001”.

5 (b) TABLE OF CONTENTS.—The table of contents of
 6 this Act is as follows:

Sec. 1. Short title; table of contents.
 Sec. 2. Findings.
 Sec. 3. Definitions.

TITLE I—REGULATORY REFORM

Sec. 101. Prospective application of certain regulations.
 Sec. 102. Requirements for judicial and regulatory challenges of regulations.
 Sec. 103. Prohibition of recovering past overpayments by certain means.
 Sec. 104. Prohibition of recovering past overpayments if appeal pending.
 Sec. 105. Prohibition of random prepayment audits.
 Sec. 106. Exception on prohibition of waiving medicare copayment.
 Sec. 107. Effective date.

TITLE II—APPEALS PROCESS REFORMS

Sec. 201. Construction of hearing rights related to decisions to deny or not
 renew a physician enrollment agreement.
 Sec. 202. Reform of post-payment audit process.
 Sec. 203. Definitions relating to physicians, providers of services, and providers
 of ambulance services.
 Sec. 204. Right to appeal on behalf of deceased beneficiaries.
 Sec. 205. Effective date.

TITLE III—EDUCATION COMPONENTS

Sec. 301. Designated funding levels for physician and provider education.
 Sec. 302. Information requests.

TITLE IV—SUSTAINABLE GROWTH RATE REFORMS

Sec. 401. Inclusion of regulatory costs in the calculation of the sustainable
 growth rate.

TITLE V—POLICY DEVELOPMENT REGARDING E&M GUIDELINES

Sec. 501. Policy development regarding E&M Documentation Guidelines.

7 **SEC. 2. FINDINGS.**

8 Congress finds the following:

1 (1) Congress should focus more resources on
2 and work with physicians and health care providers
3 to combat fraud in the medicare program.

4 (2) The overwhelming majority of physicians
5 and other providers in the United States are law-
6 abiding citizens who provide important services and
7 care to patients each day.

8 (3) Physicians and other providers of services
9 that participate in the medicare program often have
10 trouble wading through a confusing and sometimes
11 even contradictory maze of medicare regulations.
12 Keeping track of the morass of medicare regulations
13 detracts from the time that physicians have to treat
14 patients.

15 (4) Due to the overly complex nature of medi-
16 care regulations and the risk of being the subject of
17 an aggressive government investigation, many physi-
18 cians are leaving the medicare program, limiting the
19 number of medicare patients they see, or refusing to
20 accept new medicare patients at all. If this trend
21 continues, health care for the millions of patients na-
22 tionwide who depend on medicare will be seriously
23 compromised. Congress has an obligation to prevent
24 this from happening.

1 (5) Regulatory fairness for physicians and pro-
 2 viders as well as increased access to education about
 3 medicare regulations are necessary to preserve the
 4 integrity of our health care system and provide for
 5 the health of our population.

6 **SEC. 3. DEFINITIONS.**

7 In this Act:

8 (1) BILLING.—The term “billing” includes any
 9 requirement related to the content and timing of an
 10 order for care or a plan of treatment by a physician,
 11 a provider of service, or a provider of ambulance
 12 services.

13 (2) CARRIER.—The term “carrier” means a
 14 carrier (as defined in section 1842(f) of the Social
 15 Security Act (42 U.S.C. 1395u(f))) with a contract
 16 under title XVIII of such Act to administer benefits
 17 under part B of such title.

18 (3) EXTRAPOLATION.—The term “extrapo-
 19 lation” has the meaning given such term in section
 20 1861(w)(1) of the Social Security Act (as added by
 21 section 203(a)).

22 (4) FISCAL INTERMEDIARY.—The term “fiscal
 23 intermediary” means a fiscal intermediary (as de-
 24 fined in section 1816(a) of the Social Security Act
 25 (42 U.S.C. 1395h(a))) with an agreement under sec-

1 tion 1816 of such Act to administer benefits under
2 part A or B of such title.

3 (5) HCFA.—The term “HCFA” means the
4 Health Care Financing Administration.

5 (6) MEDICARE PROGRAM.—The term “medicare
6 program” means the health benefits program under
7 title XVIII of the Social Security Act (42 U.S.C.
8 1395 et seq.).

9 (7) PHYSICIAN.—The term “physician” has the
10 meaning given such term in section 1861(r) of the
11 Social Security Act (42 U.S.C. 1395x(r)).

12 (8) PREPAYMENT REVIEW.—The term “prepay-
13 ment review” has the meaning given such term in
14 section 1861(w)(2) of the Social Security Act (as
15 added by section 203(a)).

16 (9) PROVIDER OF SERVICES.—The term “pro-
17 vider of services” has the meaning given such term
18 in section 1861(u) of the Social Security Act (42
19 U.S.C. 1395x(u)).

20 (10) PROVIDER OF AMBULANCE SERVICES.—
21 The term “provider of ambulance services” means a
22 provider of ambulance services described in section
23 1861(s)(7) of the Social Security Act (42 U.S.C.
24 1395x(s)(7)).

1 (11) SECRETARY.—The term “Secretary”
 2 means the Secretary of Health and Human Services.

3 **TITLE I—REGULATORY REFORM**

4 **SEC. 101. PROSPECTIVE APPLICATION OF CERTAIN REGU-** 5 **LATIONS.**

6 Section 1871(a) of the Social Security Act (42 U.S.C.
 7 1395hh(a)) is amended by adding at the end the following
 8 new paragraphs:

9 “(3) Any regulation described under paragraph
 10 (2) shall not take effect earlier than the effective
 11 date of the final regulation. Any regulation described
 12 under such paragraph that applies to an agency ac-
 13 tion, including any agency determination, shall only
 14 apply as that regulation is in effect at the time that
 15 agency action is taken.

16 “(4) The Secretary shall issue a final rule with-
 17 in 12 months of the date of publication of an interim
 18 final rule. Such final rule shall provide responses to
 19 comments submitted in response to the interim final
 20 rule. Such final rule shall not establish or change a
 21 legal standard not raised in the interim final rule
 22 unless a new 60-day comment period is provided.

23 “(5) Carriers, fiscal intermediaries, and States
 24 pursuant to an agreement under section 1864 shall
 25 not apply new policy guidances or policy changes

1 retroactively to services provided before the date the
 2 new policy was issued.”.

3 **SEC. 102. REQUIREMENTS FOR JUDICIAL AND REGU-**
 4 **LATORY CHALLENGES OF REGULATIONS.**

5 (a) RIGHT TO CHALLENGE CONSTITUTIONALITY AND
 6 STATUTORY AUTHORITY OF HCFA REGULATIONS.—Sec-
 7 tion 1872 of the Social Security Act (42 U.S.C. 1395ii)
 8 is amended to read as follows:

9 “APPLICATION OF CERTAIN PROVISIONS OF TITLE II

10 “SEC. 1872. Subject to subparagraphs (A), (B), (D),
 11 and (E) of section 1848(i)(1), the provisions of sections
 12 206 and 216(j), and of subsections (a), (d), (e), (h), (i),
 13 (j), (k), and (l) of section 205, shall also apply with respect
 14 to this title to the same extent as they are applicable with
 15 respect to title II, except that—

16 “(1) in applying such provisions with respect to
 17 this title, any reference therein to the Commissioner
 18 of Social Security or the Social Security Administra-
 19 tion shall be considered a reference to the Secretary
 20 or the Department of Health and Human Services,
 21 respectively; and

22 “(2) section 205(h) shall not apply with respect
 23 to any action brought against the Secretary under
 24 section 1331, 1346, 1361, or 2201 of title 28,
 25 United States Code, regardless of whether such ac-

tion is unrelated to a specific determination of the Secretary, that challenges—

“(A) the constitutionality of any provision of this title;

“(B) the constitutionality of substantive or interpretive rules of general applicability issued by the Secretary to carry out this title”;

“(C) the Secretary’s statutory authority to promulgate such substantive or interpretive rules of general applicability; or

“(D) a finding of good cause under subparagraph (B) of the third sentence of section 553(b)(3) of title 5, United States Code, if used in the promulgation of such substantive or interpretive rules of general applicability.”.

(b) ADMINISTRATIVE AND JUDICIAL REVIEW OF SECRETARY DETERMINATIONS.—Section 1866(h) of the Act (42 U.S.C. 1395cc(h)) is amended—

(1) in paragraph (1), by striking “(1)” and all that follows and inserting the following: “(1) Except as provided in paragraph (3), an institution or agency dissatisfied with a determination by the Secretary that it is not a provider of services or with a determination described in subsection (b)(2) (regardless of whether such determination has been made by the

1 Secretary or by a State pursuant to an agreement
2 entered into with the Secretary under section 1864
3 and regardless of whether the Secretary has imposed
4 or may impose a remedy, penalty, or other sanction
5 on the institution or agency in connection with such
6 determination) shall be entitled to a hearing thereon
7 by the Secretary (after reasonable notice) to the
8 same extent as is provided in section 205(b), and to
9 judicial review of the Secretary's final decision after
10 such hearing as is provided in section 205(g), except
11 that, in so applying such sections and in applying
12 section 205(l) thereto, any reference therein to the
13 Commissioner of Social Security or the Social Secu-
14 rity Administration shall be considered a reference
15 to the Secretary or the Department of Health and
16 Human Services, respectively, and such hearings are
17 subject to the deadlines specified in paragraph
18 (2)f.”;

19 (2) by redesignating paragraph (2) as para-
20 graph (3);

21 (3) by inserting after paragraph (1) the fol-
22 lowing new paragraph:

23 “(2)(A)(i) Except as provided in clause (ii), an ad-
24 ministrative law judge shall conduct and conclude a hear-
25 ing on a determination described in subsection (b)(2) and

1 render a decision on such hearing by not later than the
2 end of the 90-day period beginning on the date a request
3 for hearing has been timely filed.

4 “(ii) The 90-day period under clause (i) shall not
5 apply in the case of a motion or stipulation by the party
6 requesting the hearing to waive such period.

7 “(B) The Department Appeals Board of the Depart-
8 ment of Health and Human Services shall conduct and
9 conclude a review of the decision on a hearing described
10 in subparagraph (A) and make a decision or remand the
11 case to the administrative law judge for reconsideration
12 by not later than the end of the 90-day period beginning
13 on the date a request for review has been timely filed.

14 “(C) In the case of a failure by an administrative law
15 judge to render a decision by the end of the period de-
16 scribed in subparagraph (A)(i), the party requesting the
17 hearing may request a review by the Departmental Ap-
18 peals Board of the Departmental of Health and Human
19 Services, notwithstanding any requirements for a hearing
20 for purposes of the party’s right to such a review.

21 “(D) In the case of a request described in subpara-
22 graph (D), the Departmental Appeals Board shall review
23 the case de novo. In the case of the failure of the Depart-
24 mental Appeals Board to render a decision on such hear-
25 ing by not later than the end of the 60-day period begin-

1 ning on the date a request for such a Department Appeals
 2 Board hearing has been filed, the party requesting the
 3 hearing may seek judicial review of the Secretary's deci-
 4 sion, notwithstanding any requirements for a hearing for
 5 purposes of the party's right to such review.

6 “(E) In the case of a request described in subpara-
 7 graph (D), the court shall review the case de novo.”; and

8 (4) by adding at the end the following new
 9 paragraph:

10 “(4) An institution or agency dissatisfied with a find-
 11 ing or determination by the Secretary, or by a State pur-
 12 suant to an agreement under section 1864, that the insti-
 13 tution of agency is out of compliance with any standard
 14 or condition of participation under this title (except a de-
 15 termination described in subsection (b)(2)) shall be enti-
 16 tled to a formal review or reconsideration of the finding
 17 or determination, in accordance with the regulations pre-
 18 scribed by the Secretary, prior to the imposition of any
 19 remedy, penalty, corrective action, or other sanction in
 20 connection with the finding or determination.”.

21 **SEC. 103. PROHIBITION OF RECOVERING PAST OVERPAY-**
 22 **MENTS BY CERTAIN MEANS.**

23 (a) IN GENERAL.—Subject to section 104 and except
 24 as provided in subsection (b) and notwithstanding sections
 25 1815(a), 1842(b), and 1861(v)(1)(A)(ii) of the Social Se-

1 curity Act (42 U.S.C. 1395g(a), 1395u(a), and
 2 1395x(v)(1)(A)(ii)), or any other provision of law, for pur-
 3 poses of applying sections 1842(b)(3)(B)(ii),
 4 1866(a)(1)(B)(ii), 1870, and 1893 of such Act (42 U.S.C.
 5 1395u(b)(3)(B)(ii), 1395cc(a)(1)(B)(ii), 1395gg, and
 6 1395ddd) to pending and future audits, the Secretary
 7 shall give a physician, provider of services, or provider of
 8 ambulance services the option of entering into an arrange-
 9 ment to offset alleged overpayments against future pay-
 10 ments or entering into a repayment plan with its carrier
 11 or fiscal intermediary to recoup such an overpayment.
 12 Under such an arrangement or plan, a physician, provider
 13 of services, or provider of ambulance services shall have
 14 up to 3 years to offset or repay the overpayment if the
 15 amount of such overpayment exceeds \$5,000.

16 (b) EXCEPTION.—This section shall not apply to
 17 cases in which the Secretary finds clear and convincing
 18 evidence of fraud or similar fault on the part of the physi-
 19 cian, provider of services, or provider of ambulance serv-
 20 ices or in the case of overpayments for which an offset
 21 arrangement is in place as of the date of the enactment
 22 of this Act.

1 **SEC. 104. PROHIBITION OF RECOVERING PAST OVERPAY-**
 2 **MENTS IF APPEAL PENDING.**

3 Notwithstanding any provision of law, for purposes
 4 of applying sections 1842(b)(3)(B)(ii), 1866(a)(1)(B)(ii),
 5 1870, and 1893 of the Social Security Act (42 U.S.C.
 6 1395u(b)(3)(B)(ii), 1395cc(a)(1)(B)(ii), 1395gg, and
 7 1395ddd), the Secretary may not take any action (or au-
 8 thorize any other person, including any fiscal inter-
 9 mediary, carrier, and contractor under section 1893 of
 10 such Act (42 U.S.C. 1395ddd)) to recoup an overpayment
 11 or to impose a penalty during the period in which a physi-
 12 cian, provider of services, or provider of ambulance serv-
 13 ices is appealing a determination that such an overpay-
 14 ment has been made or the amount of the overpayment.

15 **SEC. 105. PROHIBITION OF RANDOM PREPAYMENT AUDITS.**

16 Carriers may not, prior to paying a claim under the
 17 medicare program, demand the production of records or
 18 documentation absent cause.

19 **SEC. 106. EXCEPTION ON PROHIBITION OF WAIVING MEDI-**
 20 **CARE COPAYMENT.**

21 (a) IN GENERAL.—Section 1128A(i)(6)(A) of the So-
 22 cial Security Act (42 U.S.C. 1320a–7a(i)(6)(A)) is amend-
 23 ed by inserting “, except for written, mailed communica-
 24 tion with existing patients,” before “waiver is not”.

1 (b) EFFECTIVE DATE.—The amendment made by
 2 subsection (a) shall apply to communications made on or
 3 after the date of the enactment of this Act.

4 **SEC. 107. EFFECTIVE DATE.**

5 Except as otherwise provided in section 106(b), the
 6 amendments made by this title shall take effect 60 days
 7 after the date of enactment of this Act.

8 **TITLE II—APPEALS PROCESS**
 9 **REFORMS**

10 **SEC. 201. CONSTRUCTION OF HEARING RIGHTS RELATED**
 11 **TO DECISIONS TO DENY OR NOT RENEW A**
 12 **PHYSICIAN ENROLLMENT AGREEMENT.**

13 Section 1842 of the Social Security Act (42 U.S.C.
 14 1395u) is amended by adding at the end the following new
 15 subsection:

16 “(u) A carrier decision to deny an initial physician
 17 enrollment application and a carrier decision not to renew
 18 a physician enrollment agreement shall be treated as an
 19 initial determination subject to the same course of appeals
 20 as other initial determinations under section 1869.”.

21 **SEC. 202. REFORM OF POST-PAYMENT AUDIT PROCESS.**

22 (a) CARRIERS.—Section 1842 of the Social Security
 23 Act (42 U.S.C. 1395u), as amended by section 201, is fur-
 24 ther amended by adding at the end the following new sub-
 25 section:

1 “(v) In carrying out its contract under subsection
2 (b)(3), with respect to physicians’ services or ambulance
3 services, the carrier shall provide for the recoupment of
4 overpayments in the following manner:

5 “(1)(A) During the 1-year period (or 18-month
6 period in the case of a physician who is in a practice
7 with fewer than 10 full-time equivalent employees,
8 including physicians) beginning on the date on which
9 a physician or provider of ambulance services re-
10 ceives an overpayment, the physician or provider of
11 ambulance services may return the overpayment
12 without penalty or interest to the carrier making
13 such overpayment if—

14 “(i) the carrier has not requested any rel-
15 evant record or file; or

16 “(ii) the case has not been referred before
17 the date of repayment to the Department of
18 Justice or the Office of Inspector General.

19 “(B) If a physician or provider of ambulance
20 services returns an overpayment under subpara-
21 graph (A), neither the carrier, contractor under sec-
22 tion 1893, nor any law enforcement agency may
23 begin an investigation or target such physician or
24 provider of ambulance services based on any claim

1 associated with the amount the physician or provider
2 of ambulance services has repaid.

3 “(2) If a carrier has decided to conduct a post-
4 payment audit of the physician or provider of ambu-
5 lance services, the carrier shall send written notice
6 to the physician or provider of ambulance services.
7 If the physician or provider of ambulance services
8 practices in a rural area (as defined in section
9 1886(d)(2)(D)), such notice must be sent by reg-
10 istered mail.

11 “(3) The carrier or a contractor under section
12 1893 may not recoup or offset payment amounts
13 based on extrapolation (as defined in section
14 1861(w)(1)) for the first time that the physician or
15 provider of ambulance services is alleged as a result
16 of a post-payment audit to have received an overpay-
17 ment.

18 “(4) As part of any written consent settlement
19 communication, the carrier or a contractor under
20 section 1893 shall clearly state that the physician or
21 provider of ambulance services may submit addi-
22 tional information (including evidence other than
23 medical records) to dispute the overpayment amount
24 without waiving any administrative remedy or right
25 to appeal the amount of the overpayment.

1 “(5)(A) Each consent settlement communica-
2 tion from the carrier or a contractor under section
3 1893 shall clearly state that prepayment review (as
4 defined in section 1861(w)(2)) may be imposed
5 where the physician or provider of ambulance serv-
6 ices submits an actual or projected repayment to the
7 carrier or a contractor under section 1893. Subject
8 to subparagraph (D), any prepayment review shall
9 cease when the physician or provider of ambulance
10 services has submitted claims, found by carrier to be
11 covered services and coded properly for the same
12 services that were the basis for instituting the pre-
13 payment review, in a 180-day period or after proc-
14 essing claims of at least 75 percent of the volume of
15 the claims (whichever occurs first) received by the
16 carrier in the full month preceding the start of the
17 prepayment review. The 180-day period begins with
18 the date of the carrier’s written notification that the
19 physician or provider of ambulance services is being
20 placed on prepayment review.

21 “(B) Prepayment review may not be applied
22 under this part as a result of the voluntary submis-
23 sion of a claim or record under section 1897(b)(2)
24 or as a result of information provided pursuant to

1 a request under section 302(b) of the Medicare Edu-
2 cation and Regulatory Fairness Act of 2001.

3 “(C) Carrier prepayment and coverage policies
4 and claims processing screens used to identify claims
5 for medical review must be incorporated as part of
6 the education programs on medicare policy and
7 proper coding made available to physicians and pro-
8 viders of ambulance services.

9 “(D) The time and percentage claim limitations
10 in paragraph (5)(A) shall not apply to cases that
11 have been referred to the Department of Justice or
12 the Office of the Inspector General.”.

13 (b) FISCAL INTERMEDIARIES.—Section 1816 of the
14 Social Security Act (42 U.S.C. 1395h) is amended by add-
15 ing at the end the following new subsection:

16 “(m) In carrying out its agreement under this sec-
17 tion, with respect to payment for items and services fur-
18 nished under this part, the fiscal intermediary shall pro-
19 vide for the recoupment of overpayments in the following
20 manner:

21 “(1)(A) During the 1-year period beginning on
22 the date on which a provider of services receives an
23 overpayment, the provider of services may return the
24 overpayment without penalty or interest to the fiscal
25 intermediary making such overpayment if—

1 “(i) the fiscal intermediary has not re-
2 quested any relevant record or file; or

3 “(ii) the case has not been referred before
4 the date of repayment to the Department of
5 Justice or the Office of Inspector General.

6 “(B) If a provider of services returns an over-
7 payment under subparagraph (A), neither the fiscal
8 intermediary, contractor under section 1893, nor
9 any law enforcement agency may begin an investiga-
10 tion or target such provider of services based on any
11 claim associated with the amount the provider of
12 services has repaid.

13 “(2) If a fiscal intermediary has decided to con-
14 duct a post-payment audit of the provider of serv-
15 ices, the fiscal intermediary shall send written notice
16 to the provider of services. If the provider of services
17 practices in a rural area (as defined in section
18 1886(d)(2)(D)), such notice must be sent by reg-
19 istered mail.

20 “(3) The fiscal intermediary or a contractor
21 under section 1893 may not recoup or offset pay-
22 ment amounts based on extrapolation (as defined in
23 section 1861(ww)(1)) for the first time that the pro-
24 vider of services is alleged as a result of a post-pay-
25 ment audit to have received an overpayment.

1 “(4) As part of any written consent settlement
2 communication, the fiscal intermediary or a con-
3 tractor under section 1893 shall clearly state that
4 the provider of services may submit additional infor-
5 mation (including evidence other than medical
6 records) to dispute the overpayment amount without
7 waiving any administrative remedy or right to appeal
8 the amount of the overpayment.

9 “(5)(A) Each consent settlement communica-
10 tion from the fiscal intermediary or a contractor
11 under section 1893 shall clearly state that prepay-
12 ment review (as defined in section 1861(ww)(2))
13 may be imposed where the provider of services sub-
14 mits an actual or projected repayment to the fiscal
15 intermediary or a contractor under section 1893.
16 Subject to subparagraph (D), any prepayment re-
17 view shall cease when the provider of services has
18 submitted claims, found by the fiscal intermediary to
19 be covered services and coded properly for the same
20 services that were the basis for instituting the pre-
21 payment review, in a 180-day period or after proc-
22 essing claims of at least 75 percent of the volume of
23 the claims (whichever occurs first) received by the
24 fiscal intermediary in the full month preceding the
25 start of the prepayment review. The 180-day period

1 begins with the date of the fiscal intermediary's
2 written notification that the provider of services is
3 being placed on prepayment review.

4 “(B) Prepayment review may not be applied
5 under this part as a result of the voluntary submis-
6 sion of a claim, cost report, or record under section
7 1897(b)(2) or as a result of information provided
8 pursuant to a request under section 302(b) of the
9 Medicare Education and Regulatory Fairness Act of
10 2001.

11 “(C) Fiscal intermediary prepayment and cov-
12 erage policies and claims processing screens used to
13 identify claims for medical review must be incor-
14 porated as part of the education programs on medi-
15 care policy and proper coding made available to pro-
16 viders of services.

17 “(D) The time and percentage claim limitations
18 in paragraph (5)(A) shall not apply to cases that
19 have been referred to the Department of Justice or
20 the Office of the Inspector General.”.

21 **SEC. 203. DEFINITIONS RELATING TO PHYSICIANS, PRO-**
22 **VIDERS OF SERVICES, AND PROVIDERS OF**
23 **AMBULANCE SERVICES.**

24 (a) IN GENERAL.—Section 1861 of the Social Secu-
25 rity Act (42 U.S.C. 1395 et seq.), as amended by section

1 102(b) and 105(b) of the Medicare, Medicaid, and SCHIP
 2 Benefits Improvement and Protection Act of 2000 (as en-
 3 acted into law by section 1(a)(6) of Public Law 106–554),
 4 is amended by adding at the end the following new sub-
 5 section:

6 “Definitions Relating to Physicians, Providers of
 7 Services, and Providers of Ambulance Services

8 “(ww) For purposes of provisions of this title relating
 9 to physicians, providers of services, and providers of am-
 10 bulance services:

11 “(1) EXTRAPOLATION.—The term ‘extrap-
 12 olation’ means the application of an overpayment dol-
 13 lar amount to a larger grouping of claims than those
 14 in the audited sample to calculate a projected over-
 15 payment figure.

16 “(2) PREPAYMENT REVIEW.—The term ‘pre-
 17 payment review’ means a carrier’s and fiscal
 18 intermediary’s practice of withholding claim reim-
 19 bursements from physicians, providers of services,
 20 and providers of ambulance services pending review
 21 of a claim even if the claims have been properly sub-
 22 mitted and reflect medical services provided.”.

1 **SEC. 204. RIGHT TO APPEAL ON BEHALF OF DECEASED**
 2 **BENEFICIARIES.**

3 Notwithstanding section 1870 of the Social Security
 4 Act (42 U.S.C. 1395gg) or any other provision of law, the
 5 Secretary shall permit any physician, provider of services,
 6 and provider of ambulance services to appeal any deter-
 7 mination of the Secretary under the medicare program on
 8 behalf of a deceased beneficiary where no substitute party
 9 is available.

10 **SEC. 205. EFFECTIVE DATE.**

11 The amendments made by this title shall take effect
 12 at the end of the 180-day period beginning on the date
 13 of the enactment of this Act.

14 **TITLE III—EDUCATION**
 15 **COMPONENTS**

16 **SEC. 301. DESIGNATED FUNDING LEVELS FOR PHYSICIAN**
 17 **AND PROVIDER EDUCATION.**

18 (a) EDUCATION PROGRAMS FOR PHYSICIANS, PRO-
 19 VIDERS OF SERVICES, AND PROVIDERS OF AMBULANCE
 20 SERVICES.—Title XVIII of the Social Security Act (42
 21 U.S.C. 1395 et seq.) is amended by adding at the end
 22 the following new section:

23 “EDUCATION PROGRAMS FOR PHYSICIANS, PROVIDERS OF
 24 SERVICES, AND PROVIDERS OF AMBULANCE SERVICES

25 “SEC. 1897. (a) EDUCATION PROGRAM DEFINED.—
 26 In this section, the term ‘education programs’ means pro-

1 grams undertaken in conjunction with health care associa-
 2 tions that focus on current billing, coding, cost reporting,
 3 and documentation laws, regulations, program memo-
 4 randa, instructions to regional offices, and fiscal inter-
 5 mediary and carrier manual instructions that place special
 6 emphasis on billing, coding, cost reporting, and docu-
 7 mentation errors that the Secretary has found occur fre-
 8 quently and remedies for these improper billing, coding,
 9 cost reporting, and documentation practices.

10 “(b) CONDUCT OF EDUCATION PROGRAMS.—

11 “(1) IN GENERAL.—Carriers, fiscal inter-
 12 mediaries, and contractors under section 1893 shall
 13 conduct education programs for any physician (or a
 14 designee), provider of services, or provider of ambu-
 15 lance services that submits a claim or cost report
 16 under paragraph (2)(A). Such carriers, inter-
 17 mediaries, and contractors under section 1893 shall
 18 conduct outreach to specifically contact physicians
 19 and their designees, providers of services, and pro-
 20 viders of ambulance services with fewer than 10 full-
 21 time-equivalent employees (including physicians) to
 22 implement education programs tailored to their edu-
 23 cation needs and in proximity to their practices.

24 “(2) PROVIDER EDUCATION.—

1 “(A) SUBMISSION OF CLAIMS, COST RE-
2 PORTS, AND RECORDS.—Any physician, pro-
3 vider of services, or provider of ambulance serv-
4 ices may voluntarily submit any present or prior
5 claim, cost report, or medical record to the car-
6 rier or fiscal intermediary to determine whether
7 the billing, coding, and documentation associ-
8 ated with the claim or cost report is appro-
9 priate.

10 “(B) PROHIBITION OF EXTRAPOLATION.—
11 No claim submitted under subparagraph (A) is
12 subject to any type of extrapolation (as defined
13 in section 1861(w)(1)).

14 “(C) SAFE HARBOR.—No submission of a
15 claim, cost report, or record under this section
16 shall result in the carrier, fiscal intermediary, a
17 contractor under section 1893, or any law en-
18 forcement agency beginning an investigation or
19 targeting an investigation based on any claim,
20 cost report, or record submitted under such
21 subparagraph.

22 “(3) TREATMENT OF CLAIMS.—If the carrier or
23 fiscal intermediary finds a claim or cost report under
24 paragraph (2) to be improper, the physician, pro-

vider of services, or provider of ambulance services
shall have the following options:

“(A) CORRECTION OF PROBLEMS.—To
correct the documentation, coding, or billing
problem to appropriately substantiate the claim
or cost report and either—

“(i) remit the actual overpayment; or

“(ii) receive the appropriate additional
payment from the carrier or fiscal inter-
mediary.

“(B) REPAYMENT.—To repay the actual
overpayment amount if the service is excluded
from medicare coverage under this title or if
adequate documentation does not exist.

“(4) PROHIBITION OF PHYSICIAN AND PRO-
VIDER OF SERVICES TRACKING.—Carriers, fiscal
intermediaries, and contractors under section 1893
may not use the record of attendance or information
gathered during an education program conducted
under this section or the inquiry regarding claims or
cost reports under paragraph (2)(A) to select, iden-
tify, or track such physician, provider of services, or
provider of ambulance services for the purpose of
conducting any type of audit or prepayment re-
view.”.

1 (b) FUNDING OF EDUCATION PROGRAMS.—

2 (1) MEDICARE INTEGRITY PROGRAM.—Section
 3 1893(b)(4) of such Act (42 U.S.C. 1395ddd(b)(4))
 4 is amended by adding at the end the following new
 5 sentence: “No less than 10 percent of the program
 6 funds shall be devoted to the education programs for
 7 physicians, providers of services, and providers of
 8 ambulance services under section 1897.”.

9 (2) CARRIERS.—Section 1842(b)(3)(H) of such
 10 Act (42 U.S.C. 1395u(b)(3)(H)) is amended by add-
 11 ing at the end the following new clause:

12 “(iii) No less than 2 percent of carrier
 13 funds shall be devoted to the education
 14 programs for physicians under section
 15 1897.”.

16 (3) FISCAL INTERMEDIARIES.—Section
 17 1816(b)(1) of such Act (42 U.S.C. 1395h(b)(1)) is
 18 amended—

19 (A) in subparagraph (A), by striking
 20 “and” at the end;

21 (B) in subparagraph (B), by striking “;
 22 and” and inserting a comma; and

23 (C) by adding at the end the following new
 24 subparagraph:

1 “(C) that such agency or organization is
2 using no less than 1 percent of its funding for
3 education programs for providers of services
4 and providers of ambulance services under sec-
5 tion 1897.”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to fiscal years beginning after the
8 date of the enactment of this Act.

9 **SEC. 302. INFORMATION REQUESTS.**

10 (a) CLEAR, CONCISE, AND ACCURATE ANSWERS.—
11 Fiscal intermediaries and carriers shall do their utmost
12 to provide physicians, providers of services, and providers
13 of ambulance services with a clear, concise, and accurate
14 answer regarding billing and cost reporting questions
15 under the medicare program, and will give their true first
16 and last names to such physicians, providers of services,
17 and providers of ambulance services.

18 (b) WRITTEN REQUESTS.—

19 (1) IN GENERAL.—The Secretary shall establish
20 a process under which a physician, provider of serv-
21 ices, or provider of ambulance services may request,
22 free of charge and in writing from a fiscal inter-
23 mediary or carrier, assistance in addressing ques-
24 tions regarding coverage, billing, documentation,
25 coding, and cost reporting procedures under the

1 medicare program and then the fiscal intermediary
2 or carrier shall respond in writing within 30 busi-
3 ness days with the correct substantive or procedural
4 answer.

5 (2) USE OF WRITTEN STATEMENT.—

6 (A) IN GENERAL.—Subject to subpara-
7 graph (C), a written statement under para-
8 graph (1) may be used by the physician, pro-
9 vider of services, or provider of ambulance serv-
10 ices who submitted the information request and
11 submitted claims in conformance with the an-
12 swer of the carrier or fiscal intermediary as
13 proof against a future audit or overpayment al-
14 legation under the medicare program.

15 (B) EXTRAPOLATION PROHIBITION.—Sub-
16 ject to subparagraph (C), no claim submitted
17 under this section shall be subject to extrapo-
18 lation, if the claim adheres to the conditions set
19 forth in the information response.

20 (C) LIMITATION ON APPLICATION.—Sub-
21 paragraphs (A) and (B) shall not apply to cases
22 of fraudulent billing.

23 (3) SAFE HARBOR.—If a physician, provider of
24 services, or provider of ambulance services requests
25 information under this subsection, neither the fiscal

1 intermediary, the carrier, a contractor under section
2 1893 of the Social Security Act (42 U.S.C.
3 1395ddd), nor any law enforcement agency may
4 begin an investigation or target such physician or
5 provider based on the request.

6 (c) BROAD POLICY GUIDANCE BY THE SEC-
7 RETARY.—The Secretary shall develop a mechanism to ad-
8 dress written questions regarding medicare policy and reg-
9 ulations, which are submitted by health care associations.
10 The Secretary shall issue such answers within 90 calendar
11 days from the date of the receipt of the question and shall
12 make the responses available to the public in an indexed,
13 easily accessible format.

14 (d) NOTICE OF CHANGES IN POLICY.—Carriers and
15 fiscal intermediaries shall provide written, mailed notice
16 within 30 calendar days to physicians, providers of serv-
17 ices, and providers of ambulance services of all policy or
18 operational changes to the medicare program. Physicians,
19 providers of services, and providers of ambulance services
20 shall have not less than 30 days to comply with such policy
21 changes.

22 (e) EFFECTIVE DATE.—This section shall take effect
23 180 days after the date of the enactment of this Act.

TITLE IV—SUSTAINABLE GROWTH RATE REFORMS

SEC. 401. INCLUSION OF REGULATORY COSTS IN THE CALCULATION OF THE SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f)(2) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)) is amended—

(1) by redesignating subparagraphs (A) through (D) as clauses (i) through (iv), respectively;

(2) by striking “SPECIFICATION OF GROWTH RATE.—The sustainable growth rate” and inserting “SPECIFICATION OF GROWTH RATE.—

“(A) IN GENERAL.—The sustainable growth rate”; and

(3) by adding at the end the following new subparagraphs:

“(B) INCLUSION OF SGR REGULATORY COSTS.—The estimate established under clause (iv) or any successor thereto shall include—

“(i) the impact on costs for physicians’ services resulting from regulations implemented by the Secretary during the year for which the sustainable growth rate is estimated, including those regulations

1 that may be implemented during such
2 year; and

3 “(ii) the costs described in subpara-
4 graph (C).

5 “(C) INCLUSION OF OTHER REGULATORY
6 COSTS.—The costs described in this subpara-
7 graph are per procedure costs incurred by phy-
8 sicians’ practices in complying with regulations
9 promulgated by the Secretary, regardless of
10 whether such regulation affects the fee schedule
11 established under subsection (b)(1).

12 “(D) INCLUSION OF COSTS IN REGU-
13 LATORY IMPACT ANALYSES.—With respect to
14 any regulation promulgated that may impose a
15 regulatory cost described in subparagraph
16 (B)(i) or (C) on a physician, the Secretary shall
17 include in the regulatory impact analysis ac-
18 companying such regulation an estimate of any
19 such cost.

20 “(E) INCLUSION OF ESTIMATED COST ON
21 RURAL PHYSICIANS.—In promulgating regula-
22 tions, the Secretary shall specifically estimate
23 the costs to rural physicians and physicians
24 practices in rural areas and the estimated num-

1 ber of hours needed to comply with the regula-
2 tion.”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 subsection (a) shall apply with respect to any estimate
5 made (or regulation promulgated) by the Secretary of
6 Health and Human Services on or after 1 year after the
7 date of enactment of this Act.

8 **TITLE V—POLICY DEVELOP-**
9 **MENT REGARDING E&M**
10 **GUIDELINES**

11 **SEC. 501. POLICY DEVELOPMENT REGARDING E&M DOCU-**
12 **MENTATION GUIDELINES.**

13 (a) IN GENERAL.—HCFA may not implement any
14 new evaluation and management documentation guidelines
15 (in this section referred to as “E&M guidelines”) under
16 the medicare program, unless HCFA—

17 (1) has provided for an assessment of the pro-
18 posed guidelines by organizations representing physi-
19 cians;

20 (2) has established a plan that contains specific
21 goals, including a schedule, for improving use of
22 such guidelines;

23 (3) has completed a minimum of 4 pilot
24 projects consistent with subsection (b) in at least 4
25 different HCFA regions administered by 4 different

1 carriers (to be specified by the Secretary) to test
 2 such guidelines; and

3 (4) finds that the objectives described in sub-
 4 section (c) will be met in the implementation of such
 5 guidelines.

6 (b) PILOT PROJECTS.—

7 (1) LENGTH AND CONSULTATION.—Each pilot
 8 project under this subsection shall—

9 (A) be of sufficient length to allow for pre-
 10 paratory physician and carrier education, anal-
 11 ysis, and use and assessment of potential E&M
 12 guidelines; and

13 (B) be conducted, throughout the planning
 14 and operational stages of the project, in con-
 15 sultation with organizations representing physi-
 16 cians.

17 (2) PEER REVIEW PILOT PROJECTS.—Of the
 18 pilot projects conducted under this subsection—

19 (A) at least one shall focus on a peer re-
 20 view method by physicians (not employed by a
 21 carrier) which evaluates medical record infor-
 22 mation for claims submitted by physicians iden-
 23 tified as statistical outliers relative to defini-
 24 tions published in the CPT book;

1 (B) at least one shall be conducted for
 2 services furnished in a rural area (as defined in
 3 section 1886(d)(2)(D) of the Social Security
 4 Act, 42 U.S.C. 1395ww(d)(2)(D)); and

5 (C) at least one shall be conducted in a
 6 setting where physicians bill under physicians
 7 services in teaching settings (described in sec-
 8 tion 415.150 of title 42, Code of Federal Regu-
 9 lations).

10 (3) BANNING OF TARGETING OF PILOT
 11 PROJECT PARTICIPANTS.—Data collected under this
 12 subsection shall not be used as the basis for overpay-
 13 ment demands or post-payment audits.

14 (4) STUDY OF IMPACT.—Each pilot project
 15 shall examine the effect of the E&M guidelines on—

16 (A) different types of physician practices,
 17 including those with few than 10 full-time em-
 18 ployees (including physicians); and

19 (B) the costs of physician compliance, in-
 20 cluding education, implementation, auditing,
 21 and monitoring.

22 (c) OBJECTIVES FOR E&M GUIDELINES.—The objec-
 23 tives for E&M guidelines specified in this subsection are
 24 as follows (relative to the E&M guidelines and review poli-
 25 cies in effect as of the date of the enactment of this Act):

1 (1) Enhancing clinically relevant documentation
 2 needed to code accurately and assess coding levels
 3 accurately.

4 (2) Decreasing the level of non-clinically perti-
 5 nent and burdensome documentation time and con-
 6 tent in the record.

7 (3) Increased accuracy by carrier reviewers.

8 (4) Education of both physicians and reviewers.

9 (5) Promote appropriate use of E&M codes by
 10 physicians and their staffs.

11 (6) The extent to which the tested E&M docu-
 12 mentation guidelines substantially adhere to the
 13 CPT coding definitions and rules.

14 (d) REPORT ON HOW MET PILOT PROJECT OBJEC-
 15 TIVES.—HCFA shall submit a report to the Committees
 16 on Energy and Commerce and Ways and Means of the
 17 House of Representatives, the Committee on Finance of
 18 the Senate, and the Practicing Physicians Advisory Coun-
 19 cil, six months after the conclusion of the pilot projects.
 20 Such report shall include the extent to which the pilot
 21 projects met the objectives specified in subsections (b)(4)
 22 and (c).

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